



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF PHARMACY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

REPORT OF PHARMACIST-IN-CHARGE CHANGE

INSTRUCTIONS

File this form whenever the Pharmacist-in-Charge (PIC) of a Delaware-licensed Pharmacy changes.

- **An outgoing (former) PIC must notify the Board of Pharmacy in writing within 10 days of termination as PIC.**
- **The incoming (new) PIC must sign the PHARMACIST-IN-CHARGE ACKNOWLEDGMENT on this form.**

The following requirements apply to the incoming (new) PIC for all Delaware-licensed Pharmacies (in-state or non-resident):

- The incoming PIC will be responsible for all operations of the pharmacy.
- The PIC of a Nuclear Pharmacy must be a Qualified Nuclear Pharmacist. He or she is responsible for all operations of the pharmacy and must be personally on the premises at all times that the Pharmacy is open for business.
- The incoming PIC must read the responsibilities listed in Section 3.1 of the Board's [Rules and Regulations](#).

If the Pharmacy is *in Delaware*, the following additional requirements apply to the incoming (new) PIC

- The incoming PIC must hold a Delaware Pharmacist license.
- The incoming PIC may serve as a PIC for only one pharmacy at a time.
- If the incoming PIC has not previously served as a PIC in Delaware, he or she must appear personally at a [regularly scheduled Board meeting](#) within 90 days of assuming the position.
- The incoming PIC must complete the [Pharmacist-in-Charge Self-Inspection](#) form within 30 days of assuming the duties of PIC and by February 1 of each year thereafter.

You may submit this form by mail, fax or email (as a scanned attachment).

PHARMACY INFORMATION

1. Name of Business (as it appears on license): _____
2. Pharmacy's Delaware License Number: A ____ - _____
3. **Location Address:** _____
Street (No PO Boxes) City State Zip

PHARMACIST-IN-CHARGE INFORMATION

4. Enter the following information about the **OUTGOING** Pharmacist-in-Charge:
Full Name: _____
Is this person a Delaware-licensed pharmacist? Yes ☐ No ☐ If yes, enter Delaware license: **A1-** _____
Enter the effective date of Pharmacist-in-Charge change: _____
5. Enter the following information about the **INCOMING** Pharmacist-in-Charge:
Full Name: _____
Is this person a Delaware-licensed pharmacist? Yes ☐ No ☐ If yes, enter Delaware license: **A1-** _____

INCOMING PHARMACIST-IN-CHARGE ACKNOWLEDGMENT

I understand that I am responsible for conducting and managing the prescription department in compliance with all applicable state and federal laws.

Have you read and understood your responsibilities in Section 3.1 of the Board's [Rules and Regulations](#)? Yes ☐ No ☐

Do you agree to notify the Board of Pharmacy in writing within 10 days of your termination as pharmacist-in-charge? Yes ☐ No ☐

Pharmacist-in-Charge Signature: _____ **Email:** _____

To receive news and alerts from the Delaware Board, a current email address is essential.

If you are Delaware-licensed Pharmacist, you can keep your contact information up-to-date online at [Change Contact Information](#).

If you are not Delaware-licensed, mail or email contact information changes to the Board office